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No. _____

IN THE

Supreme Court of the United States

October Term, 1988

DR. ALAN S. KURITZKY, *et al.*,

Petitioners,

vs.

BLUE SHIELD OF WESTERN NEW YORK, INC., *et al.*,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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Questions Presented

Whether the agencies and entities which administer Medicare Part B may determine health care providers' reimbursements using methods which contravene the Social Security Act and Regulations and the agencies' and entities' own Manuals without being accountable to federal courts.

The Courts of Appeal for the Third, Sixth and Ninth Circuits, and the Court of Claims would grant jurisdiction to hear this case relying on *Bowen v. Michigan Academy of Family Physicians*, 476 US 667 (1986), which held that federal courts may review the methods by which reimbursement amounts are determined, but the Second Circuit denied jurisdiction relying on *U.S. v. Erika*, 456 US 201 (1982), which held that federal courts may not review the reimbursement amounts themselves.

Also at issue is the District Court's power to review the acts of a hearing officer who arbitrarily and capriciously failed to fulfill his statutory and regulatory duties.

The final issue is the District Court's power to review a decision of a hearing officer which, assuming the hearing officer fulfilled his duties, leads to illegal results.

List of Parties (Pursuant to Rule 28.1)

Petitioners are:

Dr. Alan S. Kuritzky, Dr. Robert Schultz and Dr. Theodore Herman, Nephrology Associates of Western New York;

Dr. Sidney Anthone and Dr. Roland Anthone, Anthone & Anthone, M.D., P.C.;

Dr. Rocco Venuto, Dr. Albert D. Menno, Dr. Romesh K. Kohli and Dr. Inkee Min, Buffalo Medical Group, P.C.

None of the professional corporations have parents, subsidiaries or affiliates.

Respondents are:

Blue Shield of Western New York, Inc.;

Otis Bowen, Secretary of Department of Health and Human Services;

William Roper, Administrator of Health Care Financing Administration.

All parties below are involved in this Petition; Petitioners being plaintiffs and appellants below and Respondents being defendants and appellees below.

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Dr. Alan S. Kuritzky, Dr. Robert Schultz and Dr. Theodore Herman, Nephrology Associates of Western New York; Dr. Sidney Anthone and Dr. Roland Anthone, Anthone & Anthone, M.D., P.C.; Dr. Rocco Venuto, Dr. Albert D. Menno, Dr. Romesh K. Kohli and Dr. Inkee Min, Buffalo Medical Group, P.C. petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit.

Opinions Below

The opinion of the Court of Appeals is reported at 850 F.2d 126, and a copy is set forth in the Appendix, *infra*, at 1a-6a. The opinion of the district court is unreported, and a copy is set forth in the Appendix, *infra*, at 7a-14a.

Jurisdiction

The judgment of the Court of Appeals was entered on June 27, 1988, and a copy is set forth in the Appendix, *infra*, at 15a-16a. On September 20, 1988, Justice Marshall extended the time for filing a petition for a writ of certiorari to and including October 25, 1988.

Jurisdiction is conferred upon this Court in 28 U.S.C. §1254(1).

Statutes Involved

The statute involved is 42 U.S.C. §1395ff (specifically, subsection (b)(1)), which at times pertinent to this complaint provided:

§1395ff. Determinations of Secretary

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

> (A) whether he meets the conditions of section 426 or section 426a of this title, or
>
> (B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title or section 1819,[1] or
>
> (C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

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[1] Act of July 18, 1984 (effective July 18, 1984) deleted "or section 1819" but this amendment is irrelevant to Petitioner's case.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Appeal by institutions or agencies

Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

Statement of the Case

I. Medical Background

The nine Petitioners are medical physicians. Each one specializes in nephrology, the study and treatment of kidney disorders. A substantial part of their practices involve the treatment of patients who suffer from end-stage renal disease and its complications—a chronic condition which, left untreated, leads to death; but, with dialysis or transplantation, life expectancy is sometimes near normal. Petitioners' practices cover Western New York, and they treat approximately 400 end-stage renal disease patients, representing nearly all of the end-stage renal disease patients in Western New York. Most of these patients are on dialysis and are most susceptible to other diseases.

II. Financial Administration

Since 1972, the United States has paid for dialysis and transplants. In 1972, Congress created the End Stage Renal Disease Program ("ESRD" and "Program" respectively), now 42 USC §1395rr, a component of Medicare Part B. Congress directed the Secretary of Health and Human Services ("Secretary" and "HHS" respectively) to administer the Program. The Secretary, in turn, delegated responsibility for the Program to the Administrator of the Health Care Financing Administration ("Administrator" and "HCFA" respectively). HCFA is an HHS agency. Even so, the Administrator does not supervise the Program's daily operations. The Administrator exercises statutory power and duty by contracting with private carriers which run the daily Medicare Part B operations. See 42 USC §1395(u). Here, HCFA contracted with Blue Shield of Western New York, Inc. ("Blue Shield").

III. Carrier's Role

The Social Security Act ("Act") requires carriers to determine the amount of reimbursement a health care provider will receive. This is true not only for nephrologists who participate in the ESRD Program, but also for every hospital, doctor, clinic and medical supply house in the county which services Medicare patients (Part A or Part B). Overall, reimbursement is based either upon "reasonable charge" or "reasonable cost". Petitioners are entitled to a "reasonable charge" for their services. 42 CFR §405.501(a).

IV. Method Prescribed to Determine Amount of Reimbursement

The Secretary promulgated regulations which prescribe the *methods* carriers must use to determine the *amount* of reimbursements due to Petitioners and all other physicians who treat Medicare Part B patients. Those regulations are contained in 42 CFR Part 405. The Administrator further detailed those prescribed methods in a document called The Medicare Carriers Manual, HCFA Pub. 14 ("Manual"), for use by carriers under contract with HCFA to administer Medicare Parts A & B operations.

V. Circumstances Which Led to this Case

For the period involved in this case, 1973 to present, Petitioners were all of the nephrologists in Western New York except for one very recent practitioner.

Effective August 1, 1983, the reimbursement mechanism changed from the "Alternate Reimbursement Method" to the "Monthly Capitation Payment." When

Petitioners received notice of the new, proposed reimbursement rates from Blue Shield, they attempted to duplicate Blue Shield's calculations with their data following the prescribed methods. Petitioners' conclusions did not equal Blue Shield's. Petitioners then went to the old reimbursement formula, worked that thru, and found these were not the same either. Therefore, Petitioners inquired of HHS, HCFA and Blue Shield concerning the actual data and actual methods HHS, HCFA and Blue Shield had used to determine their reimbursements. Neither HHS, HCFA nor Blue Shield could produce evidence that they had complied with the Act, Regulations and Manual. In fact, the evidence Respondents did produce tends to show that the prescribed methods were wilfully and knowingly disregarded.

For instance, 47 FR 6567 (Feb. 12, 1982) and Manual §§5022 and 5037.3 specifically require that the carrier use specialist's fee screens in determining an ESRD physician's reimbursements. Yet, the record contains uncontroverted evidence that Blue Shield did not use *any* actual charge data much less specialist's data to determine Petitioner's reimbursements. Even though other carriers do! (See Joint Appendix in the Second Circuit at 135 ¶A.1, 182-187 and 190-194.)

In addition, 42 CFR §405.504 requires a carrier to divide the area over which it administers Medicare into "localities." Localities must reflect treatment patterns of the population and charging patterns of the physicians who treat that population. The record contains uncontroverted evidence—Blue Shield's own study—that there is "no significant variation in the physician and supplier charging patterns in our service area." (See

Joint Appendix in the Second Circuit at 169.) Nevertheless, the area administered by Blue Shield is divided into several different localities of widely differing reimbursements rates. (See Joint Appendix in the Second Circuit at 122.)

Finally, the record contains further uncontroverted evidence of other violations of the Act, Regulations and Manual.

VI. Proceedings Below

At a "fair hearing" pursuant to 42 USC §1395u (b)(3)(C), Petitioners adduced the above-mentioned evidence and showed Respondents did not follow the prescribed methods. Respondents did not appear at the hearing. The Hearing Officer, however, issued a decision against Petitioners. See Appendix, *infra*, at 17a-29a. The decision failed to deal with the facts or the issue of compliance with the regulations. The decision was subjective and illogical on its face. Petitioners, therefore, requested judicial review in the federal District Court for the Western District of New York based upon federal question jurisdiction: 5 USC §§701 and 702; 28 USC §§1331 and 1343; and 42 USC §§405 (g) and (h).

The complaint sought an injunction to prevent Respondents' further use of illegal methods and to require Respondents to use the prescribed methods. The complaint also sought an order to require Respondents to apply the prescribed regulations to Petitioners' reimbursements since 1973. The complaint further sought an order declaring that the Hearing Officer's decision was arbitrary, capricious and against the weight of the evidence.

If the relief were granted as demanded in the complaint, this case would have nationwide impact. The Secretary, the Administrator, the Medicare Carriers and every Medicare service provider in the country would audit their records, like Petitioners have already, and ascertain whether their reimbursements were determined using the lawfully prescribed methods. Furthermore, hearing officers would be more vigilant and vigorous in conducting hearings in accordance with the law, in finding facts based only upon the evidence before them, in applying those facts to the Act, Regulations and Manual, and in rendering decisions which are free of speculation and conjecture. Yet, without considering these issues, the District Court dismissed the complaint. The Court did not even hold a preliminary evidentiary hearing. The Court did, however, rely on a strained interpretation of *U.S. v. Erika, Inc.*, 456 U.S. 201 (1982).

Respondents brought the matter before the District Court by a motion for summary judgment which alleged a lack of subject-matter jurisdiction under FRCP 12 (b)(1), 42 USC §1395ff and *Erika*. Respondents argued that Petitioners simply seek more money and that Congress, in 42 USC §1395ff, and this Court, in *Erika*, have barred judicial review of claims which involve *only the amount of reimbursement itself.*

Petitioners opposed the motion, asserting firstly that their primary claim is that the *method* HHS, HCFA and Blue Shield used to determine the amount of reimbursement to ESRD physicians *was in violation* of the Act, Regulations and Manual. Secondly, Petitioners asserted that if HHS, HCFA and Blue Shield had complied with the law, then the Act, Regulations and Manual were themselves illegal because they allowed impermissible results, such as amounts of

reimbursements which vary widely among carriers and localities without any rationale basis, and such as hearing officer decisions which are arbitrary, capricious and against the weight of the evidence.

Petitioners relied on this Court's opinion (decided after *Erika*) in *Bowen v. Michigan Academy of Family Physicians,* 476 US 667 (1986), because its material facts are exactly the same as those in Petitioners' case, and the legal issues are exactly the same. This Court in *Michigan Academy* held that federal courts have subject-matter jurisdiction over these very issues notwithstanding 42 USC §1395ff and *Erika.*

Both the District Court and the Court of Appeals, though, have decided, without a trial or hearing, that Petitioners' case deals with amounts not methods; and therefore, *Erika,* which was decided after a trial and before *Michigan Academy,* controls.

This Court should act to correct the errors below and to clarify the distinction between challenges to "amounts" and challenges to "methods."

REASONS RELIED ON FOR ALLOWANCE OF THE WRIT

I. Introduction

What is the difference between the method by which an amount is determined and the amount itself? Pragmatically, any change in the method by which an amount is determined changes the amount itself; method and amount are inextricably intertwined ideas. Yet legally, in the context of Medicare Part B, method and amount are dipolar concepts which open and close the door to federal courts. As Judge Oberdorfer of the District Court for the District of Columbia obvserved, after conducting a hearing to determine whether a permanent injunction should issue, in *Health Industry Distributors Association and National Association of Medical Equipment Suppliers v. Bowen*, CCH Medicare and Medicare Guide ¶36,748 at p. 15,709 (DDC Oct. 8, 1987),

> If plaintiffs' challenge in this case can properly be characterized as a challenge to the Secretary's determination of the "*amount of benefits*" to which they are entitled under Part B of the Medicare program, then there is no question that 42 U.S.C. §1395ff applies. If §1395ff applies, then defendant is correct that the administrative review procedures provided therein must be exhausted before plaintiffs can bring their case to federal court. However, *if* plaintiffs' grievance is properly characterized as a challenge to the *methodology* by which the Secretary determines benefits, then plaintiffs have a compelling argument that *Michigan Academy* is dispositive and that the subsequent changes in §1395ff do not undercut their right to immediate judicial review in federal court. So the question of jurisdiction turns critically on whether or not the

> plaintiffs are "at bottom" simply disputing the *amount* of reimbursement they will receive under the Secretary's recent LCL notice.
>
> Plaintiffs have made a convincing showing in their pleadings and in oral argument that their challenge in this case is to the *methodology* underlying the Secretary's determination of Medicare reimbursement. This is underscored by the fact that plaintiffs are not here with vouchers to dispute individual reimbursement decisions but rather are representing a community of medical suppliers who have an interest in the method by which reimbursement calculations are made. Hence, under Michigan Academy, this court has jurisdiction to hear their claim.

(Emphasis added.)

Thus, method and amount are legal concepts which require factual determinations. Notice how Judge Oberdorfer, in the context of a hearing, something Petitioners have not had, needed to rely on the *fact* that the plaintiffs before him did not present vouchers and ask for money in return. Notice how he weighed the evidence and decided that the facts tended to show that the case involved methods not amounts "at bottom."

Obviously, these concepts of method and amount are difficult to untangle. Courts have waited until after a trial or evidentiary hearing to determine whether cases before them involve amounts or methods. This is true of *Michigan Academy*, of *Health Industry*, and of many other decisions of district courts; even *Erika* itself involved a trial. Yet, Judge Elfvin below decided that Petitioners' claims do not involve methods even though he never looked at the facts behind the complaint which on its face challenges methods.

This distinction between methods and amounts is so important to the fair administration of the nation-wide, multi-million dollar Medicare Part B program, and the law is currently so tricky to apply, that this Court should act to clarify the distinctions between method and amount. This Court should announce guidelines to help federal judges: clarify the distinction, revise the definitions, or require a trial or at least an evidentiary hearing on the issue.

The instant case provides an opportunity to forestall future litigation of this issue by clarifying how the Secretary, the Administrator and carriers all over the country should administer Medicare Part B. The instant case also affords this Court with an opportunity to correct the erroneous decision of the Court of Appeals below; a decision out-of-step with the Third, Sixth, and Ninth Circuits, and out-of-step with the Court of Claims' decision in *Erika* upon which the Second Circuit relies.

II. The Third Circuit

The case at bar would have been within the scope of federal subject-matter jurisdiction if it had arisen in the Third Circuit.

In *Medical Fund-Philadelphia Geriatric Center v. Heckler,* 804 F.2d 33 (3rd Cir. 1986), an association of physicians sued the Secretary who had reopened the claims of a nursing facility. The Secretary had paid the facility's claims as if it were a Medicare-certified facility. The facility, however, was only Medicaid-certified. Thus, the Secretary sought repayments asserting that the facility was only entitled to reimbursement at a lower non-certified rate. The facility, through its association, sued to enjoin the recoupment of alleged overpayments.

The facility argued that since it was Medicaid-certified, and since the statutory requirements for Medicaid certification were identical to those for Medicare certification, then the facility was entitled to reimbursements as if it were Medicare-certified even though it had not completed the clerical task of applying for Medicare certification.

The district court, relying on *Erika*, dismissed the facility's complaint as merely a claim about an amount determination. While on appeal to the Third Circuit, this Court handed down *Michigan Academy*. The Third Circuit would have reversed based upon *Michigan Academy*, but the complaint did not clearly state whether the claim involved methods or amounts. Therefore, the Third Circuit remanded with leave to amend the complaint, and directed the district court to assume jurisdiction if the district court found the complaint

> challenges an explicit HCFA policy in the Medicare Carrier's Manual or challenges its lawfulness *as applied* to situations like this one.

Id., 804 F.2d at 39 (emphasis added).

The significant fact in that case was that "only one set of statutory requirements [existed] for certification as a 'skilled nursing facility' whether it be for Medicare or Medicaid purposes." *Id.*, 804 F.2d at 37. Similarly, in the case at bar, only one method for determining Petitioners' reimbursements exists. That method requires the use of specialists' fee screens, the creation of localities which do not vary irrationally, the use of physicians' actual charge data in creating specialists' fee screens and much more. Sec. 42 CFR Part 405.

Respondents have not followed those methods prescribed in the Act, Regulations and Manual, and therefore, Petitioners challenge the lawfulness of those

policies as applied to their claims. So, the Third Circuit would have held that federal courts have subject-matter jurisdiction.

III. The Sixth Circuit

The case at bar would have been within the scope of federal subject-matter jurisdiction if it had arisen in the Sixth Circuit.

In *Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan*, 502 F. Supp. 751 (EDMD 1980), *aff'd*, 728 F.2d 326 (6th Cir. 1984), *aff'd sub nom., Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), the carrier created three different categories of medical service providers. Then, the carrier purportedly applied the law with regard to "reasonable charge" to each category and created reimbursement amounts for each category. Medical service providers were reimbursed at different rates corresponding to their category even though they were providing the same services.

The plaintiffs in that case were non-board certified family physicians. The carrier paid them at the same rate, for say a brief office visit, as chiropractors, podiatrists and dentists. Board-certified family physicians received a higher amount, based upon specialists' fees, for the same service.

The heart of the issue was the propriety of the categories. The plaintiffs argued that the carrier unfairly categorized them; that they provided the same services as specialists, and therefore, they should receive the same amounts. This could have been construed as

solely a challenge to the amount of their reimbursement, but this Court and the courts below in *Michigan Academy* realized that plaintiffs there were arguing more than simply amounts. The argument was that either the regulations themselves were invalid, or the regulations were illegally applied to those plaintiffs. In either case, the regulations themselves would be invalid because the result was impermissible. This Court decided that not only *could* federal courts grant the relief, but *only* federal courts could grant the relief because these claims are outside the scope of a carrier's fair hearing.

The same issues lie at the heart of Petitioners' case. The complaint explicitly alleges that either Blue Shield is applying the Regulations illegally, or, if the application is legal, then the Regulations themselves are illegal because the Regulations require illegal results. Similarly, either the hearing officer conducted the hearing improperly (assuming for argument's sake that the matter was within the jurisdiction of a fair hearing), or the Regulations concerning the duties of a hearing officer are illegal because the Regulations allow this hearing officer to circumvent his duties to find facts and draw conclusions of law.

This Court has already held that these issues are reviewable in federal court. Therefore, Petitioners demand their rights to a trial because the evidence shows that, just as in *Michigan Academy,* the carrier here did not use actual charge data to establish reimbursement amounts and the carrier cannot justify its categories under the law. If this case had arisen in the Sixth Circuit, the trial would have been completed already because the jurisdictional issue *has* already been decided in Petitioners' favor.

IV. The Ninth Circuit

The case at bar would have been within the scope of federal subject-matter jurisdiction if it had arisen in the Ninth Circuit.

In *Linoz v. Heckler*, 800 F.2d 871 (9th Cir. 1986), Medicare Part B claimants sought reimbursement for the cost of ambulance services. The Secretary denied coverage based upon a provision in the Manual. The issue was whether that provision had been properly promulgated.

While this substantive issue differs from the Petitioners' substantive issue, the Ninth Circuit was called upon to decide whether Medicare Part B claims were reviewable. In analyzing *Michigan Academy*, the Ninth Circuit stated:

> In *Michigan Academy of Family Physicians*, the Supreme Court held that the exhaustion and judicial review provisions of the Social Security Act, incorporated by reference in the Medicare Act, 42 U.S.C. §§1395ff, 1395ii, do not insulate from review Part B regulations and instructions promulgated by the Secretary. *Id.* at _____, 106 S.Ct. at 2137-38. The Court distinguished between individual Part B benefit determinations—which are "finally and exclusively" delegated to carrier hearing officers, *id.* at _____, 106 S.Ct. at 2138-40—and the validity of the Secretary's procedures for computing Part B claims, which the Carrier's Manual expressly removes from the carriers' jurisdiction. *Id. at* _____ & n. 5, 106 S.Ct. at 2137-38 & n. 5. While the Court reaffirmed its prior holdings that Congress deliberately foreclosed judicial review with respect to typically "trivial" Part B reimbursement amounts, *id.* at _____, 106 S.Ct., at 2137-40, *see also Erika*, 456 U.S. at 208, 102 S.Ct. at 1654, the Court held that neither the legislative history nor

> the statutory framework gives "clear and convincing evidence" that Congress "intended no review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program." *Michigan Academy of Family Physicians*, _____ U.S. at _____, 106 S.Ct. at 2141 (*quoting Abbott Laboratories v. Gardner*, 387 U.S. 136, 141, 87 S.Ct. 1507, 1511-12, 18 L.Ed.2d 681 (1967)).

(Emphasis added).

Thus, the Ninth Circuit concluded that *Michigan Academy* and not *Erika* controlled; and therefore, the Ninth Circuit held that federal subject-matter jurisdiction lies in cases which claim that the Secretary's procedures for computing Part B claims are illegal. This is exactly what Petitioners claim, so if their case had arisen in the Ninth Circuit, their case would have been heard in federal court.

V. The Court of Claims

The case at bar would have been within the scope of federal subject-matter jurisdiction even if it had arisen in the Court of Claims where *Erika* was decided.

In *U.S. v. Erika, Inc.*, 456 U.S. 201 (1981), a distributor of kidney dialysis supplies challenged the amount of reimbursement it received from the carrier. The carrier reimbursed based upon prior year's catalogue prices, but the distributor sought reimbursements which reflected then current prices. The carrier did increase reimbursements for a drug whose price had increased sharply. The carrier relied on a specific HHS policy which permitted adjustments in unusual situations. Nonetheless, the distributor sought adjustments for other items and sued, after a fair hearing, to compel adjustments. After a trial, something

Petitioners have not been afforded, the Court of Claims granted jurisdiction and compelled further adjustments because it found errors in the calculations. *Id.*, 225 Ct. Cl. 252, 634 F.2d 580 (*en banc*), opinion clarified, 225 Ct. Cl. 273, 647 F.2d 129 (1981).

This Court granted certiorari to determine the issue of jurisdiction and reversed, but the facts in *Erika* are significantly different from the facts at bar.

In *Erika*, this Court reversed because the claim was within the jurisdiction of a fair hearing, the distributor did not challenge the methods the carrier used to set reimbursement amounts. In fact, this Court found that the carrier had complied with the law: it used actual charge data; it created localities which had rational relationships to facts; it even disclosed the raw data to the distributor. *Id.*, 456 U.S. at 204 and n. 2. None of this has occurred in Petitioners' case. The distributor in *Erika* challenged neither the methods nor the propriety of the conduct of the hearing. *Id.*, 456 U.S. at 205. Both issues are in contention at bar.

Petitioners seek the very judicial intervention—a trial of the issues—that even Erika, Inc. received. A federal court should find that either the Respondents complied with the proscribed methods concerning the determination of Petitioners' reimbursement and the conduct of the fair hearing, or that Respondents have acted illegally. At the very least, a federal court should compel Respondents to reveal the data and methods used; the record already contains substantial evidence that Respondents have acted illegally. Only this Court can compel them to account, and even under *Erika*, Petitioners are entitled to federal court review.

Conclusion

This Court has already held that Petitioners' claims are reviewable in federal court. *Michigan Academy* considered the same issues presented here, and the same defense—42 USC §1395ff as construed by *Erika*. In finding jurisdiction in *Michigan Academy*, this Court reasoned that *Erika*:

> simply does not speak to challenges mounted against the *method* by which such amounts are to be determined rather than the *determinations* themselves. . . . 'the legality, constitutional *or otherwise*, of any provision of the Act or regulations relevant to the Medicare Program' is not considered in a 'fair hearing' held by a carrier to resolve a grievance related to a determination of the amount of a Part B award.

Michigan Academy, 106 S.Ct. at 2138-2139, *quoting* Manual §12016 (first two emphases original).

This Court relied in part upon its analysis of the legislative history of 42 USC §1395ff to distinguish *Michigan Academy* from *Erika*, and stated that Congress desired to preclude from federal court review "quite minor matters[,] . . . decisions on a claim for payment for a given service," *Michigan Academy*, 106 S.Ct. at 2139, quoting 118 Cong. Rec. 33992 (1972), because minor matters would unduly tax federal courts and, in the end, little value would result. This Court therefore held that matters which Congress did not leave to a fair hearing *are reviewable* in federal court. *Id.* at 2140.

Here, the Second Circuit's opinion states that Petitioners have not disputed the hearing officer's authority to decide their claim. See *Kuritzky*, 850 F.2d 126, 128 (2nd Circuit 1988). However, Petitioners' claims

are not, in fact, within the authority of a hearing officer because the claims are that either the regulations as applied are illegal or the regulations themselves are illegal because they allow illegal results. Only a federal court can decide those questions, *Michigan Academy*, 106 S.Ct. at 2140.

The necessity for a decision by the Supreme Court of the United States here is best illustrated by examining the Second Circuit's opinion. The Second Circuit shows its lack of knowledge of the law in this area by stating, at 850 F.2d 128, that since Petitioners have attended a fair hearing, they have waived their rights to federal court review. This is not true. A fair hearing is the usual first step, both *Erika* and *Michigan Academy* started with a fair hearing and later had federal court trials and Supreme Court review over the legality of the events surrounding the fair hearing. Also, two clauses occur back-to-back at 850 F.2d 128. They illustrate how difficult it is to separate the concepts created by *Michigan Academy* and *Erika*. The Second Circuit stated:

> ["Method" in *Michigan Academy*] refers to the distinction between the rules, regulations, and statutes setting forth the proper computation method *and the carrier's application of those provisions in determining the benefits owed.* [Citation omitted.] "Method" does not mean the carrier's method of applying the regulations.

(Emphasis added.)

What is the difference between "the rules, regulations, and statutes setting forth the proper computation method" and "the carrier's application of those provisions in determining the benefits owed?" There should be none. If the carrier properly applies the methods, then the benefit defined by the rules, regulations, and statutes would be the same benefit as

determined by the carrier. When, as here, the Petitioners' application of the rules, regulations and statutes results in a benefit which is different from that computed by the carrier, then the court must entertain challenges to the legality, constitutional or otherwise, of those rules, regulations and statutes pursuant to *Michigan Academy*. When, as here, there is substantial evidence of a carrier's illegal acts, federal courts must grant jurisdiction pursuant to *Michigan Academy*.

The Second Circuit cannot reconcile *Michigan Academy* and *Erika*. Judge Oberdorfer, the Third, Sixth and Ninth Circuits, and the Court of Claims have struggled with the concepts of method and amount, and found jurisdiction in a wide variety of fact situations. In each, no decision occurred until after a trial or evidentiary hearing. Therefore, the Second Circuit's opinion is irreconcilable with the decisions of those courts, and the Supreme Court of the United States. This case presents the Court with an unusual opportunity to correct the Court of Appeals for the Second Circuit and restore uniformity to the administration of Medicare Part B by clarifying the concepts of "method" and "amount" in this area of law.

Wherefore, Petitioners respectfully request that this Court issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Second Circuit.

Respectfully submitted,

FREDERICK B. COHEN*
STEVEN S. FOX
Counsel for Petitioners
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Suite 425
Buffalo, New York 14202
(716) 856-6000

* *Counsel of Record*

October 1988

APPENDIX

Opinion of the United States Court of Appeals for the Second Circuit

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 1282—August Term 1987

Argued: June 22, 1988 Decided: June 27, 1988

Docket No. 88-6068

DR. ALAN S. KURITZKY, DR. ROBERT SCHULTZ and DR. THEODORE HERMAN, NEPHROLOGY ASSOCIATES OF WESTERN NEW YORK; DR. SIDNEY ANTHONE and DR. ROLAND ANTHONE, ANTHONE & ANTHONE, M.D., P.C.; DR. ROCCO VENUTO, DR. ALBERT D. MENNO, DR. ROMESH K. KOHLI, and DR. INKEE MIN, BUFFALO MEDICAL GROUP, P.C.,

Plaintiffs-Appellants,

—v.—

BLUE SHIELD OF WESTERN NEW YORK, INC., OTIS BOWEN, SECRETARY OF DEPARTMENT OF HEALTH AND HUMAN SERVICES, and WILLIAM ROPER, ADMINISTRATOR OF HEALTH CARE FINANCING ADMINISTRATION,

Defendants-Appellees.

Before:

NEWMAN, KEARSE, and CARDAMONE,

Circuit Judges.

Appeal from a judgment of the District Court for the Western District of New York (John T. Elfvin, Judge) dismissing for lack of subject matter jurisdiction plaintiffs' complaint seeking Medicare payments under Part B of the Medicare Act, 42 U.S.C. §§ 1395j-1395w (1982).

Affirmed.

FREDERICK B. COHEN, Buffalo, N.Y., *for plaintiffs-appellants.*

BARBARA SPIVACK, New York, N.Y. (Ronald E. Robertson, Gen. Counsel, Susan V. Kayser, Asst. Regional Counsel, U.S. Dept. of Health & Human Services, New York, N.Y.; Roger P. Williams, U.S. Atty., Daniel C. Olivero, Asst. U.S. Atty., Buffalo, N.Y., on the brief), *for defendants-appellees.*

PER CURIAM:

Plaintiffs, physicians practicing in Western New York, appeal from a judgment of the District Court for the Western District of New York (John T. Elfvin, Judge) dismissing for lack of subject matter jurisdiction their complaint seeking Medicare payments under Part B of the Medicare Act, 42 U.S.C. §§ 1395j-1395w (1982 & West Supp. 1988). We agree with the District Court that this case is controlled by *United States v. Erika, Inc.*, 456 U.S. 201 (1982), and we affirm.

Part B of the Medicare program is administered through private insurance carriers who contract with the Secretary of Health and Human Services (the "Secretary"). 42 U.S.C. § 1395u. The carriers reimburse physicians and other health care providers based on their "reasonable charges," as determined in accordance with the Medicare Act and the Secretary's implementing regulations. *Id.* §§ 13951, 1395u. A claimant who is unsatisfied with the amount he is reimbursed may petition for a "fair hearing" before a hearing officer designated by the carrier. *See* 42 U.S.C. § 1395u(b)(3)(C); 42 C.F.R. § 405.820 (1987).

Plaintiffs receive their Medicare reimbursements from Blue Shield of Western New York, Inc. ("Blue Shield"). Beginning in 1984, plaintiffs complained to the carrier about the way in which their benefits were computed. After a "fair hearing," the hearing officer determined that Blue Shield had complied with the applicable rules and regulations. This lawsuit followed.

In *United States v. Erika, Inc.*, *supra*, the Supreme Court held that a hearing officer's decision regarding a carrier's interpretation of "reasonable charges" was unreviewable in federal court. The Court reasoned that the Medicare Act, 42 U.S.C. § 1395ff, as it then existed, provided for judicial review of agency determinations regarding eligibility and the amount of benefits awarded under Part A but "conspicuously" did not authorize review of amount determinations under Part B. *United States v. Erika, Inc.*, *supra*, 456 U.S. at 208. The Court concluded that "[i]n the context of the statute's precisely drawn provisions, this omission provides persuasive evidence that Congress deliberately intended to foreclose further review

of such claims." *Id.*[1] Under the Act as applicable to this case, the hearing officer is therefore the final arbiter of Part B benefit amount disputes based on the carrier's application or interpretation of agency rules and regulations.

The Supreme Court delineated the limits of *Erika* in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). The Court ruled that 42 U.S.C. § 1395ff, as construed in *Erika*, did not bar a federal court challenge to "the validity of the Secretary's regulation[s]." 476 U.S. at 675. The Court explained that review is foreclosed with respect to "amount determinations," over which the hearing officer has final authority, but that "those matters which Congress did *not* leave to be determined in a 'fair hearing' conducted by the carrier—including challenges to the validity of the Secretary's instructions and regulations—are not impliedly insulated from judicial review by 42 U.S.C. § 1395ff." *Id.* at 678 (emphasis original). The distinction that emerges from *Erika* and *Michigan Academy* is that federal jurisdiction exists where there is a challenge to the validity of an agency rule or regulation, *e.g.*, *Linoz v. Heckler*, 800 F.2d 871 (9th Cir. 1986); *Integrated Generics, Inc. v. Bowen*, 678 F. Supp. 1004 (E.D.N.Y. 1988), but jurisdiction is lacking where the claim is merely that the insurance carrier misapplied or misinterpreted valid rules and regulations, *e.g.*, *Ass'n of Seat Lift Manufacturers v. Bowen*, Medicare and Medicaid Guide (CCH) ¶ 36,1101, at 13,468 (N.D. Ohio Jan. 30, 1987); *Mobile Medical Services, Inc. v. Arkansas Blue Cross and Blue Shield*, 676 F. Supp. 194 (W.D. Ark.

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1 In 1986, Congress amended section 1395ff to permit judicial review of certain Part B amount determinations. Those amendments apply only to Medicare services furnished after January 1, 1987, and are therefore not relevant to the claims in this case, which are based on services provided prior to that date.

1987). *See generally Medical Fund-Philadelphia Geriatric Center v. Heckler*, 804 F.2d 33, 36-39 (3d Cir. 1986).

Plaintiffs' claim in this case is that "Blue Shield has failed to follow the provisions of both the regulations and the [Medicare Carriers] Manual in determining" the reasonable charges to which plaintiffs are entitled. Pl. Br. at 2. This claim is indistinguishable from that in *Erika* where the Supreme Court held judicial review was foreclosed. *See United States v. Erika, Inc.*, *supra*, 456 U.S. at 205. The claim does not fall within the scope of *Michigan Academy* because plaintiffs do not attack the validity of any regulation or rule promulgated by the Secretary. Moreover, plaintiffs do not dispute that the hearing officer had authority to decide their claim in the first instance; the claim cannot therefore come within the group "which Congress did *not* leave to be determined in a 'fair hearing' conducted by the carrier," and which is reviewable in federal court. *Bowen v. Michigan Academy of Family Physicians*, *supra*, 476 U.S. at 678.

Plaintiffs contend that jurisdiction exists because they challenge the carrier's "methods" in calculating benefits. *See Bowen v. Michigan Academy of Family Physicians*, *supra*, 476 U.S. at 675. However, the statement in *Michigan Academy* that challenges to the "method" of calculating benefits are reviewable as opposed to challenges to the "determinations themselves," which are not, *id.*, clearly refers to the distinction between the rules, regulations, and statutes setting forth the proper computation method and the carrier's application of those provisions in determining the benefits owed. *Id.* at 675-76. "Method" does not mean the carrier's method of applying the regulations, which *Erika* held was unreviewable; rather, it means the method set forth in the Secretary's regulatory scheme that

prescribes how the carriers are to calculate benefits. *Michigan Academy* held that a challenge to this prescribed method was reviewable. Plaintiffs' claims allege only misapplication of valid regulations and are therefore unreviewable under *Erika*.

We have carefully considered plaintiffs' remaining arguments, and we determine that they are without merit.

The judgment of the District Court is affirmed.

Opinion of the United States District Court for the Western District of New York

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

DR. ALAN S. KURITZKY, DR. ROBERT SCHULTZ & DR. THEODORE HERMAN, NEPHROLOGY ASSOCIATES OF WESTERN NEW YORK; DR. SIDNEY ANTHONE & DR. ROLAND ANTHONE, ANTHONE & ANTHONE, M.D., P.C.; DR. ROCCO VENUTO; DR. ALBERT D. MENNO; DR. ROMESH K. KOHLI, and DR. INKEE MIN, BUFFALO MEDICAL GROUP, P.C.,

Plaintiffs,

vs.

BLUE SHIELD OF WESTERN NEW YORK, INC.; OTIS BOWEN, Secretary of Department of Health & Human Services; and WILLIAM ROPER, Administrator of Health Care Financing Administration,

Defendants.

CIV-87-76E

MEMORANDUM AND ORDER

The defendants' motion to dismiss for lack of subject matter jurisdiction squarely presents the question of judicial reviewability of the "amounts" or "the carrier's application of regulations to determine amounts" of benefits awarded to physicians under Part B of the Medicare program (subchapter XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.*). The plaintiffs allege that there is subject matter jurisdiction under 28 U.S.C. §1343, 5 U.S.C. §§701 & 702 and 42 U.S.C. §405(g) and §405(h). The defendants claim that

jurisdiction is foreclosed pursuant to 42 U.S.C. §405(h)[1] and 42 U.S.C. §1395ff. As will be developed, section 1395ff is dispositive.[2]

[1] Section 405(h) states:

"The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter." This section is incorporated into the Medicare Act pursuant to 42 U.S.C. §1395ii.

[2] §1395ff as applicable here provides:

"(a) *Entitlement to and amount of benefits.* The determination of whether an individual is entitled to benefits under Part A [Hospital Insurance Benefits for Aged and Disabled (§§1395c-1395i-2)] or Part B [Supplementary Medical Insurance Benefits for Aged and Disabled (§§1395j-1395w)] of this subchapter [XVIII Health Insurance for Aged and Disabled (§§1395-1395xx)], and the determination of the amount of benefits under Part A of the subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

"(b) *Appeal by Individuals*

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to *** (C) the amount of benefits under Part A of this subchapter *** shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title. ***."

Section 1395ff was later amended and, as amended, is applicable to services rendered on or after January 1, 1987 and as such is not applicable here inasmuch as the plaintiffs' claims are for services rendered prior to such date. 42 U.S.C. §1395ff (1982 ed. and Supp. 1987). The pertinent text of §1395ff(b)(1) as amended in 1986 is:

"(b) *Appeal by Individuals*

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to *** (C) the amount of benefits under Part A or Part B of this subchapter *** shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in Section 405(g) of this title. ***."

The plaintiffs allegedly comprise all the nephrologists or other physicians practicing medicine in the Western District of New York who participate in the End Stage Renal Disease Program ("ESRDP"). *See* 42 U.S.C. §1395rr. Defendant Bowen is the Secretary ("the Secretary") of the United States Department of Health and Human Services ("HHS"). Defendant Roper is the Administrator of the Health Care Financing Administration ("HCFA"), the HHS agency which administers the Medicare Program. Defendant Blue Shield of Western New York, Inc. ("Blue Shield") is a private insurance carrier under contract with HHS to administer Part B of the Medicare Program. *See* 42 U.S.C. §1395u.

The Medicare program is divided into two parts. Part A is a medical insurance program which provides insurance coverage for hospital care and related hospital services. Part B is a voluntary supplemental insurance program which provides for coverage of certain physician and related ancillary services. *See* 42 U.S.C. §1395*l*.[3] The ESRDP extended Medicare's Part A and Part B coverages to individuals who have permanent kidney failure and require either dialysis or transplantation. The plaintiffs' claims arise under Part B as they allege insufficient reimbursements for physicians' services due to Blue Shield's alleged misapplication of the pertinent Medicare regulations. *See* Complaint ¶¶45-73.

Part B pays the "reasonable charges" of physicians' services and various related health services such as x-rays and laboratory tests. Section 1395*l*. Benefits provided under Part B are administered by private insurance carriers pursuant to their contracts with the Secretary. Section 1395u(a)(1). The carriers—*e.g.*, Blue

[3] "*l*" connotes a lower case "L."

Shield—set reasonable charges for 80 percent of which an individual, or a provider (each of the plaintiffs) as assignee, is reimbursed according to guidelines set forth in the Medicare statute and regulations.[4] Section 1395*l*. The statute provides for "a fair hearing by the carrier" if a dispute arises over the amount of the reimbursements. Section 1395u(b)(3)(C). No administrative or judicial review of the carrier's determination is provided for in the applicable statute.

All of the plaintiffs are physicians in the ESRDP, locality 01, which is administered by Blue Shield. They were reimbursed by Blue Shield at a monthly rate of $178.20 from 1972 through June 1982, $220.00 after June 1982 through July 1983, and $197.39 thereafter. Complaint, ¶¶52-54. The plaintiffs were given a "fair hearing" regarding their objections to the reimbursements and Blue Shield's "methodology" in determining the reimbursements to be made to the plaintiffs beginning after July 1983. Complaint ¶76; Exhibit A to Defendants' Memorandum of Law in Support of its [sic] Motion to Dismiss for lack of Subject Matter Jurisdiction. The Hearing Officer found that Blue Shield had followed the statute, the regulations and the guidelines when it had determined the amount of the reimbursements. The plaintiffs now seek judicial review of the officer's findings and of the reimbursements paid to the plaintiffs from 1973 to the present.

Under the Medicare Act, 42 U.S.C. §1395 *et seq.*, Congress has provided that disputed Part B carrier determinations were subject to review in a "fair hearing

[4] For the regulations and guidelines used by the carrier in determining the reimbursements, *see* Letter and Decision of Hearing Officer pp. 2-8, Exhibit B to Defendants' Memorandum of Law in Support of its [sic] Motion to Dismiss for Lack of Subject Matter Jurisdiction.

by the carrier." Section 1395u(b)(3)(C). The Act also provides for review by the Secretary of questions of individual entitlement to benefits under Part A or Part B and of the *amount of benefits* under *Part A*. Sections 1395ff(a) and 1395ff(b)(1)(C). Further administrative review and subsequent judicial review are available in only two situations: "when the dispute relates to the eligibility to participate in either Part A or Part B, and when the dispute concerns the amount of benefits to which they are entitled under Part A. §1395ff(b)." *United States v. Erika, Inc., ("Erika")* 456 U.S. 201, 207 (1982). It is thus apparent from Section 1395ff(b)(1)(C) and *Erika* (p. 206) that there is to be no judicial review of determinations of the amount of benefits of Part B awards.

The omission by Congress, in the then applicable section 1395ff, to authorize further review of determinations of amounts of Part B awards, along with the legislative history of that section, led the Court in *Erika* (pp. 206, 208), to hold specifically that amount determinations under Part B are not reviewable in federal courts. *See also Medical Fund-Philadelphia Geriatric Center v. Blue Cross Blue Shield of Greater New York,* 432 F.Supp. 1339, 1340 (E.D.N.Y. 1977). In *Erika* the respondent was a major distributor of kidney dialysis supplies who was the assignee of persons purchasing such supplies. The carrier set the "reasonable charges" for the services according to its interpretation of the relevant statute and regulations. *Erika* (p. 204). The distributor requested the carrier to readjust its past and future reimbursements because it felt that the carrier's determination did not reflect price increases in the services. After the carrier's refusal on most of the requests the distributor sought review before a hearing officer and the officer affirmed the carrier's decision. *Id.*

at 205. The distributor then sought review in the Court of Claims, which found subject matter jurisdiction over the claim. *Erika, Inc. v. United States,* 634 F.2d 580 (Ct.Cl. 1980). The United States Supreme Court held that amount determinations under Part B are not open to judicial review.

The present case is not distinguishable from *Erika* and this Court is thus constrained to follow its holding. The Complaint alleges that Blue Shield had not determined the reasonable charge of a nephrologist's brief office visit and that it had set a single rate for specialists and non-specialists alike, both allegedly inconsistent with the Medicare Regulations and Carrier's Manual prescribed by the HCFA. Complaint, ¶¶60, 63, 68. It further alleges the actual amounts plaintiffs did receive and what they should have received if Blue Shield had followed the regulations. Complaint, ¶¶52-54, 72-73. This Court, although noting that the Complaint speaks of "application" and "methodology" (Complaint ¶¶74, 76), reads the Complaint to be nothing more than a request for judicial review of amount determinations under Part B of the Medicare Act. Accordingly, this Court does not have jurisdiction to entertain these claims.

The plaintiffs' argument for review by this Court is based on the decision in *Bowen v. Michigan Academy of Family Physicians,* _____ U.S. _____, 106 S.Ct. 2133 (1986). There the Court was faced with the question whether section 1395ff or section 1395ii of the Medicare Act barred judicial review of *regulations promulgated* under Part B. *Id.* at 2135. The Court, after first stating that there is a strong presumption in favor of judicial review of administrative action, held that Congress had not intended to bar judicial review of matters which Congress did not delegate to private carriers, such as

challenges to the validity of the Secretary's instructions and regulations. *Id.* at 2140. The Court stated that section 1395ff(b)(1)(C) does not speak to challenges mounted against the method used to determine the amounts rather than the determinations themselves. *Id.* at 2138. It is the validity or constitutionality of the Secretary's regulations and methods which is open to judicial review as they are not considered in a fair hearing by the carrier. *Id.* at 2138-2139. The Court then went on to state:

> "As a result, an attack on the validity of a regulation is not the kind of administrative action that we described in *Erika* as an 'amount determination' which decides 'the amount of the Medicare payment to be made on a particular claim' and with respect to which the Act impliedly denies judicial review." *Id.* at 2139.

It is therefore clear to this Court that *Bowen v. Michigan Academy of Family Physicians* speaks only to a review of the *Secretary's* regulations and methods and not to review of the *Carrier's* application of those regulations and of its final determination, as this is what the hearing officer explicitly decides in the fair hearing. *See,* 42 C.F.R. §§405.801 and 405.803; Letter and Decision of Hearing Officer, Exhibit B to Defendants' Memorandum of Law in Support of its Motion to Dismiss for Lack of Subject Matter Jurisdiction. The instant Complaint does not attack the validity or method of the Secretary's regulations but only the amount determinations by the carrier and, as a result, judicial review of that matter is foreclosed under section 1395ff. *Erika* (p. 206).

This Court notes the jurisdictional claim and challenge under 42 U.S.C. §405(h), as incorporated into the Medicare Act under section 1395ii, but finds as did the Court in *Erika* that the language of the Medicare statute is dispositive. Furthermore and as this Court noted in footnote 2, the 1986 change in section 1395ff(b)(1)(C) allowing for administrative and judicial review in certain circumstances for claims for services provided on or after January 1, 1987 is not applicable because the plaintiffs' claims relate to services rendered prior to January 1, 1987.[5] However, if the plaintiffs have objections to reimbursements for services rendered on or after January 1, 1987 they are free to pursue those claims, first in a "fair hearing" and then via the amended statute if applicable.

Accordingly, it is hereby ORDERED that the defendants' motion to dismiss the complaint is granted.

Dated: Buffalo, N.Y.
February 11, 1988

JOHN T. ELFVIN, *U.S.D.J.*

[5] The Complaint is dated January 15, 1987.

Judgment of the United States Court of Appeals for the Second Circuit

UNITED STATES COURT OF APPEALS

For the Second Circuit

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the 27th day of June one thousand nine hundred and eighty-eight.

Present: Hon. Jon O. Newman,
Hon. Amalya L. Kearse,
Hon. Richard J. Cardamone,
Circuit Judges.

United States Court of Appeals
Filed
Jun 27 1988
Elaine B. Goldsmith, Clerk
Second Circuit

FILED
88 Aug 11 AM 8:27
U.S. DISTRICT COURT
W.D.N.Y.—BUFFALO

Dr. Alan S. Kuritzky, Dr. Robert Schultz, and Dr. Theodore Herman, Nephrology Associates of Western New York; Dr. Sidney Anthone and Dr. Roland Anthone, Anthone & Anthone, M.D., P.C.; Dr. Rocco Venuto, Dr. Albert D. Menno, Dr. Romesh K. Kohli, and Dr. Inkee Min, Buffalo Medical Group, P.C.,

v.

Blue Shield of Western New York, Inc., Otis Bowen, Secretary of Department of Health and Human Services, and William Roper, Administrator of Health Care Financing Administration.

88-6068

Appeal from the United States District Court for the Western District of New York.

This cause came on to be heard on the transcript of record from the United States District Court for the Western District of New York, and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now hereby ordered, adjudged and decreed that the Judgment of said District Court be and it hereby is Affirmed in accordance with the opinion of this court with costs to be taxed against the appellant.

ELAINE B. GOLDSMITH, *Clerk*
By: EDWARD J. GUARDARO
Deputy Clerk

A TRUE COPY
ELAINE B. GOLDSMITH
by KATHLEEN BROWWE
Deputy Clerk

(Seal Illegible) ISSUED AS MANDATE: 8-8-88

Decision of Hearing Officer

UMD Fair Hearing Officer
750 Highland Avenue
Rochester, New York 14620
(716) 271-8230

February 14, 1986

Frederick B. Cohen, Esq.
Liberman and Cohen
120 Delaware Ave., Suite 425
Buffalo, NY 14202

Dear Mr. Cohen:

RE: Beneficiaries: Multiple
Providers: Western New York Nephrology Associates[1]
Fair Hearing Requested: 03/05/85
Date of Fair Hearing: 10/17/85
Representative: Frederick B. Cohen, Esq.

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[1] The following is the list of physicians being represented by Mr. Cohen:

Roland Anthone, M.D.
Sidney Anthone, M.D.
Anthone & Anthone, M.D., P.C.
40 North Union Rd.
Williamsville, NY 14223

Robert W. Schultz, M.D.
Theodore S. Herman, M.D.
Alan S. Kuritzky, M.D.
Nephrology Associates of Western New York
1275 Delaware Ave.
Buffalo, NY 14209

Romesh K. Kohli, M.D.
85 High St.
Buffalo, NY 14203

(Footnote continued on following page.)

ISSUE:

Has the Medicare Carrier established a proper and correct "Monthly Capitation Payment" (MCP) to physicians in the Buffalo NY area or locality 01? This is for the time period 07/01/82-08/01/83 and 08/01/83-present.

FACTS:

Since 08/01/83 the MCP rate for the above providers have been $197.39. It can be noted that it was raised from an original profile of $158.56 but this should not be an issue as the payments paid before the change have been corrected. The providers feel the correct approved amount should be $220.

The providers feel that approved amounts prior to 08/01/83 were also not correct. I have 4 files that have been reviewed by Medicare which are for services after 08/01/83 and I will first base my decision for services during this time period.

(Footnote continued from preceding page.)

Albert D. Menne, M.D.
1616 Kensington Ave.
Buffalo, NY 14215

Rocco Venuto, M.D.
462 Grider St. Room 207
Buffalo, NY 14215

Inkee Min, M.D.
85 High St.
Buffalo, NY 14203

This letter will serve as my decision in the above matter.

STATEMENT OF ISSUES & LAW:

The following is from the Carrier's Manual with a revision date of July 1983:

5037.3 *Determining the Monthly Capitation Payment For A Physician's Services to Maintenance Dialysis Patients.*—The MCP is based on the local prevailing charges for fee screen year 1981 for medical specialists' brief followup office visits for an established patient (CPT-4 Code 90040) and intermediate followup office visit (CPT-4 Code 90060). (See SS13650ff. (Exhibit I) for a description of these service codes.) The medical specialists to use in selecting the prevailing charge data are the same medical specialists that you use in reporting the prevailing charges to HCFA per SS13650ffe. In most cases this will be the prevailing charge determined from specialists in internal medicine.

A separate MCP rate is determined for each locality in the carrier's service area, and this rate is used to reimburse all physicians furnishing dialysis services in that locality. The appropriate locality is determined by the location of the patient's facility, since most of the physician's services are furnished at the facility. Therefore, even in the case of home dialysis patients, the locality in which the patient's facility is located determines the appropriate locality for determining the physician's MCP. The physician's individual customary charges are not used in determining his/her MCP.

The calculation of the monthly percentage is described below. The MCP is subject to a minimum of $144 and a maximum of $220.

A. *Calculating the Monthly Payment Rate*

1. Obtain the prevailing charge for the brief followup office visit for established patient (CPT-4 Code 90040 or equivalent) for medical specialists for fee screen year 1981. Use the same medical specialist's prevailing charges that you reported to HCFA per SS1365ff.

2. Multiply the charge by 12.4.

3. Obtain the prevailing charge for the intermediate followup office visit for established patient (CPT-4 Code 90060 or equivalent) for medical specialists for fee screen year 1981. Use the same medical specialist's prevailing charges that you reported to HCFA per SS1365ff.

4. Add the prevailing charge obtained in step 3 to the result obtained from step 2.

5. Multiply the result of step 4 by 0.949.

6. If the result of step 5 is less than or equal to $144, the monthly payment rate for that locality is $144.

7. If the result of step 5 is greater than or equal to $220, the monthly payment rate for that locality is $220.

8. If the result of step 5 is greater than $144 and less than $220, the monthly payment for that locality is the result of step 5.

Apply the deductible and coinsurance requirements to this rate.

I would like to note here that in a letter dated 07/24/85 from Mr. Cohen, he wrote:

We then went step by step through the regulations. Both informed that Upstate does not use the regulations. It only uses a manual prepared by HCFA. When I showed Petersdorf and Przybysz the regulations, they claimed

that the regulations did not apply. It was explained that the regulations are for everybody. Their position was that the regulations did not apply to Upstate and furthermore that they had letters from the Feds indicating that what was done was correct.

The Manual is written in Baltimore or Washington and is based on the regulations. The government office or quasi-government office such as Blue Shield of Western New York uses the manual for their guidelines. I don't believe it is true that the regulations do not apply to Upstate but they do follow their Manual per their instructions.

The following is from the Completion of the Social Security Laws as amended through 04/01/84:

1881(b)(7) The Secretary shall provide by regulation for a method (or methods) for determining prospectively the amounts of payments to be made for dialysis facilities to individuals in a facility and to such individuals at home. Such method (or methods) shall provide for the prospective determination of a rate (or rates) for each mode of care based on a single composite weighted formula (which takes into account the mix of patient's who receive dialysis services at a facility or at home and the relative costs of providing such services in such settings) for hospital-based facilities and such a single composite weighted formula for other renal dialysis facilities, or based on such other method or combination of methods which differentiate between hospital-based facilities and other renal dialysis facilities and which the Secretary determines, after detailed analysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas. The Secretary shall provide for such exceptions to such methods as may be warranted by unusual

circumstances (including the special circumstances of sole facilities located in isolated, rural areas). The Secretary may provide that such method will serve in lieu of any target reimbursement rate that would otherwise be established.

The following is from the Federal Register dated 02/12/82:

We currently set the ARM monthly allowance based on prevailing charges for a medical specialist's brief follow-up office visit to an established patient (CRVS Code 90040). For a particular locality, we would multiply the prevailing charge for this service by 20 for in-facility dialysis, and by 14 for home dialysis. (We also set a maximum monthly allowance of $260 and $182 respectively). Under our regulations at 42 CFR 405.542(b), these monthly payments are not automatically updated by the economic index used to adjust prevailing charges for fee-for-service physician payments under Part B. Instead, we monitor the program and update the payments as necessary in light of ESRD program objectives and experience to reflect changes in their charging practices and modes of furnishing services, and to assure fairness.

C. Proposed Rate-Setting Methodology for Physician Capitation Payments

We propose to establish equal monthly capitation payment for both home and in-facility dialysis, using a composite weighting formula to account for the proportion of patients currently dialyzing at home. We propose also to revise the basis for relating the capitation payment to prevailing charges for certain medical procedures using the most recent available prevailing charges.

We propose to use this figure of 12.4 sessions as a base multiplier. This multiplier would be applied to the local prevailing charge for a medical specialist's brief follow-up office visit for an established patient (CRVS Code 90040). (Note that we are assuming that a physician will see the patient during every dialysis 149 times per year.) We would then add to the resulting figure an amount representing a routine monthly examination, based on the prevailing charge for an intermediate follow-up office visit (CRVS Code 90060).

We would weight this sum for the national averages of patients dialyzing in-facility (83 percent) and at home (17 percent). We would weight for the infacility proportion by multiplying the sum based on the medical procedure model by .83, and would weight for the home proportion by multiplying the base sum by .17. We then multiplied that result by .7, which represents the 10:7 facility/home physician treatment capability ratio used under the current ARM.

We expect this to yield an average monthly capitation payment of $184.08. We computed this by using the median prevailing charges for CRVS Codes.

EVALUATION OF THE RECORD:

The provider feels that the figures used by the Carrier in their Manual section 5037.3 were not correct.

1. The provider's position is that Blue Shield sets up a system of interpreting these payment formulas so that market conditions were never factored into the calculation of physician fees in locality 01.

I am going to refer to sections of Determination of Reasonable Charges Under Part B of Medicare (HCFA-20036) dated February 1980:

In the administration of the medical insurance program, the carrier has primary responsibility for determining reasonable charges. The careful determination of reasonable charges in a way which is equitable both to those rendering the services and to those paying the premiums is a very important responsibility. The possible impact on fees charged in applying the criteria for determining reasonable charges. The amount of future premiums under the medical insurance program will be directly affected by carrier performance in determining reasonable charges.

The reasonable charge determination made by carriers are not normally reviewed by the Health Care Financing Administration on a case-by-case basis. However, the Health Care Financing Administration has an overall responsibility for the administration of the supplementary medical insurance program. The basic methods and procedures used by carriers in determining reasonable charges must therefore by consistent with the law, the regulations, and the broad principles and policy guidelines issued by the Health Care Financing Administration.

2. The provider feels that there is poor justification in the set up of locality 01.

Again I wish to cite from HCFA-20036:

For the purpose of making reasonable charge determinations, a locality is the geographic area for which the carrier is to derive the prevailing charges for procedures and services. Usually a locality will be a political or economic subdivision of a State and must include a cross-section of the population with respect to economic and other characteristics. Where people tend to gravitate toward certain population centers to obtain

medical care or service, localities may be recognized on a basis constituting medical service areas (interstate or otherwise), comparable to concept to "trade areas."

Carriers delineate localities on the basis of their knowledge of local conditions. The localities may differ in population density, economic level, and other major factors affecting charges for services. However, localities are not so finely made that they would include only limited areas or small population groups (e.g., a very rich or very poor neighborhood).

This is taken from section 5020.1 in the Carrier's Manual.

3. Used in the calculation is the prevailing charge for the brief followup office visit for established patient (CPT-4 code 90040 or equivalent) for medical specialists for fee screen year 1981.

Taken from HCFA-20036 is:

Charging practices in a locality may be different for physicians who practice different specialities; e.g., general practitioners, internists, etc. Existing variations in the level of charges between different kinds of practice or service could, in some localities, lead to the development of more than one prevailing charge screen. Carriers are responsive to the existing patterns of charges made by physicians in the service area and therefore establish separate prevailing charges for different specialities, but only where this would be in accord with actual practice.

The provider in his Exhibit 4 has furnished information regarding approved sources of data in the required sequence for Prevailing Charge Screens. After listing the 6 steps it concludes:

The steps described above may not always achieve a perfect result. However, beneficiaries, physicians, and suppliers do have the right to question a carrier's determination in a given case. In such instances, the carrier should use its best judgment based on the data available to it (including information the physician or supplier may furnish) to resolve the issue.

From the Carrier's Manual:

5022. If the carrier has not established a locality prevailing charge for the service by specialty or group of specialities as described in item A below, and as provided for in S5020 the carrier must select the locality prevailing charge from the remaining sources of data (items B through F inclusive), *following that sequence in strict order.* The first charge available in the sequence of sources of data will be selected as the locality prevailing charge. The economic index limitation is applied *only* to locality prevailing charges, not to the sources of data from which they were derived.

Approved Sources of Data in the Required Sequence

A. Prevailing charge by locality and by specialty or group of specialties;

B. Prevailing charge by carrier service area and by specialty or group of specialties;

C. Prevailing charge by locality without regard to specialty;

D. Prevailing charge by carrier service area without regard to specialty; and

E. Array of actual charges. Where items A through D have not produced an acceptable prevailing charge and where at least four physicians or other persons in the

carrier service area (without regard to locality or specialty) have submitted charges for a service (but four "qualified customary charges" are not available), the carrier should array all available *actual* charges for that service—set the prevailing charge for that service at the 75th percentile of that array.

F. Prevailing charge conversion factor multiplied by the appropriate relative value units. Where the carrier has not been able to establish a prevailing charge for a service on the basis of the five preceding steps, a prevailing charge conversion factor (S5022.1) and a relative value scale should be used, manually if necessary, to determine a prevailing charge. (See S5205 regarding charges for rare or unusual procedures. This is to be used as a last resort before basing the prevailing charge on the carrier's best judgment).

The instructions in section 5037.3.A.1., are to use the prevailing charge for the specialist reported for screen year 1981. Since it appears the Carrier did not have prevailing charges by specialty, he went to step C, which is prevailing charge by locality without regard to specialty. The carrier must feel that they used its best judgment based on the data available.

I would like to refer back to a letter that Mr. Cohen received dated 03/01/84 from HCFA. "The Carrier has never set separate prevailing charges by specialty and this is the carrier's prerogative based on their judgment of the characteristics of the area".

I see no reason why a fee survey would be necessary. Medicare receives data on a regular basis to establish a prevailing rate. They have the charges to establish the 75th percentile. I can see no reason for a fee survey.

4. In order to calculate the MPR it is necessary to have the prevailing charge for CPT code 90040 and 90060. What has been reported to HCFA and appearing on the computer printouts supplied by Medicare for screen year 1981 is $15 for 90040 and $22 for 90060.

By using the formula established and in Exhibit 9A furnished by the providers, the correct MPR for this period is $197.39, which has been allowed in locality 01.

FINDINGS OF FACT:

1. Each one of the providers is able to get a listing of their customary and prevailing charges from the Professional Relations Department of the Medicare Carrier. This would show them exactly how their prevailing charge has been completed for codes 90040 and 90060. I doubt this has been done since a Fee Survey has been submitted. This same information would be on their listing.

2. Why wasn't a medical specialist fee established for these two codes? Exhibit 4, indicates that a required sequence is necessary and the Carrier used step C, which is a prevailing charge by locality. This information is supplied by the computer printouts.

3. Another problem area is why the Buffalo area receives less than the Rochester area for the same procedure or why does locality 02 receive more than 01. It can also be said why does locality 01 receive more than 03 and 04.

Medicare payments for the same service, therefore, may vary from one locality to another and from one physician to another in the same locality. This payment variation reflects the patterns of charges that physicians and suppliers of services have themselves established over time.

4. I am not going to be specific regarding charges prior to 08/01/83 since the Review was based on the time period since that date. The request dated 01/11/85 referred to the period 08/01/83 to the present only. Regardless, I would assume the decision for this earlier time period would be the same.

DECISION:

The Medicare Carrier has established a "Monthly Capitation Payment" (MCP) in the Buffalo N.Y. area (locality 01) according to the regulations and guidelines. I believe the providers still have one recourse open to them. That is to follow the section in the Doctor's Manual dealing with the Professional Relations department. That would be to object to their prevailing allowances. There is nothing in the regulations that say the Carrier must establish a locality prevailing charge for the service by specialty or group of specialties. If the required sequence is followed which I decided that it has, that would be sufficient. The providers may want to outline to the PR Department why steps A and B wold be the "fair way". This should help in future Medicare payments.

Your file is being sent to the carrier, Blue Shield of Western New York Inc., Upstate Medicare Division, 15 Chenango Street, Binghamton, New York 13901; any further questions or correspondence should be directed to them in care of the Fair Hearing Section.

Thank you for your cooperation in this matter.

Sincerely,

RICHARD D. SANOW
Richard D. Sanow
Hearing Officer

RDS/nw

cc: Blue Shield of Western New York Inc.
Upstate Medicare Division